STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115329	A. Building B. Wing	10/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harborview Health Systems Thomaston	310 Avenue F Thomaston, GA 30286

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 25117 Based on observation, staff interviews, record reviews, and review of the facility policy titled Medication Administration, the facility failed to provide medications according to physician orders and in accordance with professional standards for one of three sampled residents (R) (R14) observed during the medication pass. This failure has the potential to place R14 at risk of inadequate medication effectiveness due to improper administration of medication. Findings include: A review of the facility's policy and procedure titled, Medication Administration, dated 6/1/2024, indicated: Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Policy Explanation and Compliance Guidelines: . 12) Compare medication source (bubble pack, vial, etc.) with MAR [Medication Administration Record] to verify resident name, medication name, form, dose, route, and time . b. Administer within 60 minutes prior to or after scheduled time unless otherwise ordered by physician . Medication timing (excludes insulin): BID [twice per day] 9:00 am, 9:00 pm QD [daily] 9:00 am During a medication pass observation on 10/1/2024, at 12:24 pm, Licensed Practical Nurse (LPN) BB prepared and administered the following medications to R14: 1. Calcium carbonate (calcium supplement) tablet 600 MG (milligrams), give one tablet by mouth two times a day for supplementation. 2. Lacosamide (anti-seizure medication) oral tablet 100 MG, give one tablet by mouth two times a day for seizure prophylaxis. 3. Metoprolol tartrate (anti-hypertension medication) tablet, give 12.5 MG by mouth two times daily for atrial fibrillation. 4. Nifedipine ER [extended release] (anti-hypertension medication) oral tablet 24-hour 30 MG, give one tablet by mouth one time a day for hypertension. 5. Digoxin (medication to treat heart failure) tablet 125 MG, give 0.5 MG tablet by mouth one time a day for heart failure. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Januvia (anti-diabetes medication) oral tablet 50 MG, give one tablet by mouth one time a day for elevated blood sugar. 7. Zoloft (anti-depressant medication) oral tablet 50 MG, give 50 MG tablet by mouth one time a day for depression. 8. Vitamin D3 (vitamin D supplement) tablet 5000 units, give one tablet by mouth one time a day for supplement. During an interview on 10/1/2024, at 12:33 pm, LPN BB confirmed the medications should have been administered in the morning as ordered by the physician. LPN BB further revealed that she was not able to give morning medications to R14 due to answering phone calls, giving ice to her assigned residents, and speaking with her supervisor. A review of R14's E-MAR (Electronic Medication Administration Record) dated 10/1/2024 revealed the eight medications observed administered to R14 were scheduled for morning medications. LPN BB documented the medications were administered on 10/1/2024 at 1:22 p.m. During an interview on 10/1/2024 at 3:00 pm Unit Manager (UM) AA revealed that LPN BB should have administered morning medications one hour before or one hour after 9:00 am. UM AA revealed that she called the Nurse Practitioner (NP) to reevaluate R14 due to the delayed medication administration.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25117 Based on observation, resident and staff interview, record review, and review of the facility policy titled Activities of Daily Living (ADLs), the facility failed to ensure that one of 15 sampled residents (R) (R8) received necessary assistance with incontinent care. This deficient practice placed R8 at risk for unmet needs and a diminished quality of life. Findings include: Review of the facility's policy titled Activities of Daily Living (ADLs), last revised 3/1/2023, revealed .Care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming and oral care; .3. Toileting; .Policy Explanation and Compliance Guidelines: .3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene .5. The facility will maintain individual objectives of the care plan and periodic review and evaluation. 1. Review of R8's clinical record revealed diagnoses included diabetes mellitus type II and morbid obesity. Review of R8's Annual Minimum Data Set (MDS) assessment dated [DATE] revealed R8 was cognitively intact, required substantial/maximal assistance for personal hygiene, toileting, and bathing, and was always incontinent of bowel and bladder. Review of R8's Incontinence Care Plan dated 7/13/2022 revealed the resident was incontinent related to impaired mobility, wore adult briefs at all times, and staff assisted the resident with perineal care as needed. Interventions included for staff to check the resident frequently for incontinence, and wash, rinse, and dry perineum and to change clothing as needed after incontinence episodes. During an observation and interview on 10/1/2024 at 1:30 pm, R8 was observed in bed wearing a hospital gown and had blankets that covered his lower extremities. During an interview, R8 confirmed that he was incontinent of bowel and bladder. R8 stated staff changed his incontinent brief one time per day and that his brief was last changed on the previous overnight shift. He further stated his brief had not been changed since the start of the current shift which started at 7:00 am, and stated he was lucky to have it changed twice per day. R8 was asked if he was currently dry, and the resident said that he was not. When asked about notifying staff about assisting him with perineal care, the resident said he felt staff let it be known that they did not want to care for him because he was of larger stature, and therefore, he did not want to bother them. R8 said that he expected to be changed once per day and that change usually occurred during the overnight shift. In a follow-up observation and interview on 10/1/2024 at 4:00 pm, R8 remained in his bed and wearing the same gown that was observed on him during the earlier observation/interview. R8 stated that staff still had not been into his room to change his brief during the current day shift. The resident stated that he expected to be changed on the overnight shift. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/2/2024 at 10:55 am, Certified Nursing Aide (CNA) DD revealed she worked with R8 regularly. CNA DD stated that she bathed and changed R8's brief one time during her 12-hour day shift. CNA DD further stated it was routine for the resident's brief to be changed one time during the day shift and one time during the overnight shift. In an interview on 10/3/2024 at 10:17 am, CNA II revealed that R8's brief was changed twice per day, once during the day shift and once during the overnight shift. CNA II stated that R8 would refuse to have his brief changed at times and would also refuse to have two staff assist with the changing of his brief. CNA II further stated two people were needed for the task. Continued interview revealed there were times when urine from the resident's leaking brief would accumulate on the floor under the resident's bed. In a follow-up interview on 10/3/2024 at 10:40 am, R8 stated he did not refuse incontinent care from staff. R8 further stated he insisted staff provide him privacy during care, however, the resident denied refusing assistance from staff for perineal care after he had soiled his brief. In a follow-up interview on 10/3/2044 at 10:50 am, CNA DD revealed she had only ever known R8 to refuse weights, and she had not experienced the resident refusing to have his brief changed when he was soiled.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25117 Based on staff interviews, record review, and review of the facility policy titled Social Services, the facility failed to ensure that medically related social services were provided to one of 15 sampled residents (R) (R9) who exhibited behavioral issues. This deficient practice had the potential for R9 not to receive the appropriate treatment and services, preventing R9 from maintaining their highest level of functioning and enhancing their well-being. Findings include: Review of the facility's policy titled Social Services, last revised on 3/1/2024, noted, Policy: The facility, regardless of size, will provide medically-related social services to each resident, to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Definitions: 'Medically-related social services' are services provided by the facility's staff to assist residents in attainment or maintenance of a resident's highest practicable well-being. Policy Explanation and Compliance Guidelines: .3. The social worker, or social service designee, will complete an initial and quarterly assessment of each resident, identifying any need for medically-related social services of the resident. Any need for medically-related social services will be documented in the medical record. 4. The social worker, or social service designee, will pursue the provision of any identified need for medically-related social services of the resident. Attempts to meet the needs of the resident will be handled by the appropriate discipline(s). Services to meet the resident's needs may include: a. Advocating for residents and assisting them in assertion of their rights within the facility. b. Assisting residents in voicing and obtaining resolution to grievances about treatment, living conditions, visitation rights and accommodation of needs .g. Making referrals and obtaining needed services from outside services .j. Providing or arranging for needed mental and psychosocial counseling services .n. Identifying and promoting individualized, non-pharmacological approaches to care that meet the mental and psychosocial needs of each resident .5. The facility should provide social services or obtain needed services from outside entities during situations that include but not limited to the following: .b. Expressions or indications of distress that can affect the resident's mental and psychological well-being, resulting from depression, chronic diseases (e.g., Alzheimer's disease and other dementia related diseases, schizophrenia, multiple sclerosis), difficulty with personal interaction and socialization skills, and resident to resident altercations; .e. Need for emotional support. 6. The resident's plan of care will reflect any ongoing medically-related social service needs, and how these needs are being addressed. 7. The social worker, or social service designee, will monitor the resident's progress in improving physical, mental, and psychosocial functioning. [sic] Review of R9's clinical record revealed an admitted [DATE] with diagnoses that included hemiplegia following cerebral infarction, bipolar disorder, and insomnia. Review of R9's Admission Minimum Data Set (MDS) assessment dated [DATE] revealed Section C (Cognitive Patterns) documented a Brief Interview for Mental Status (BIMS) score of 15 (indicating little to no cognitive deficit). Section D (Mood) documented a score of 12 on the Mood Severity Score. Section I (Active diagnoses) documented manic depression (bipolar disease). Section N (Medications) documented R9 was administered an antidepressant medication during the assessment period. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R9's Physician's Orders revealed the following orders: 6/4/2024 to 9/26/2024: Sertraline hydrochloride (HCl), (a Selective Serotonin Reuptake Inhibitor [SSRI] antidepressant) 50 mg (milligrams), one tab (tablet) po (by mouth) q (every) d (day) for depression. 9/25/2024: Trazadone HCl 100 mg, one tab po q hs (at bedtime) for insomnia. 9/29/2024: Sertraline HCl 100 mg, one tab po qd for depression. 9/29/2024: Lamictal 25 mg, one tab po bid (twice per day) for bipolar disorder. Review of a Thirty Day Discharge Notice addressed to R9 and dated 7/29/2024 noted the facility's Administrator signed off on the notice, which documented the following: This letter is to provide you with notice that [R9] will be discharged from Harborview of [NAME] effective 08.28.2024 which is at least thirty (30) days from the date of this letter. [R9] is being discharged due to lack of professional boundaries with staff as well as residents some examples include, but not limited to; using profanity towards staff, interfering with other residents' care. He's saying inappropriate comments to staff and has been seen entering a female resident's room even after going over resident's rights. Many department heads have pulled resident to the side to speak about behaviors on multiple occasions to educate resident on misconduct. Resident received warning 1 & 2 on July 10th, warning 3 on July 12th, and the final warning on July 29th. Resident was educated after each warning was discussed. Review of the supporting documentation of the four 'warnings' that R9 received was noted as follows: 7/10/2024: I, [R9] understand that I am getting a warning due to my behavior towards staff such as yelling and cussing at them. I understand that multiple warnings will result in a 30-day discharge. The document was signed by R9, the Administrator, and the Social Service Director (SSD). 7/10/2024: I, [R9] understand that I am getting a warning due to my behavior of going into a female room and being disrespectful to staff when informed of the issue. I understand that multiple warnings will result in a 30-day discharge. The document was signed by R9, the Administrator, and the SSD. 7/12/2024: I, [R9] understand that I am getting a third warning due to my behavior of harassing a staff member even after being asked to wait and to move away from that staff member, and also interfering with other resident's care during med pass. I understand that this is my final warning and next one will be a 30-d [day] discharge. R9 refused to sign the warning; however, the document was signed by the Administrator and the SSD. 7/29/2024: I, [R9] understand that I am getting a final warning due to my behavior on 7/26 of following a staff member and making comments about her body and making her feel uncomfortable. I understand that I am receiving a 30-day discharge as of today. R9 refused to sign the warning; however, the document was signed by the Administrator and the SSD. Review of R9's comprehensive care plan dated 6/4/2024 revealed the following care area plans: (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Placement care plan initiated 6/20/2024: R9 will remain at the facility long term at this time due to his being unable to care for himself. Behavioral care plan initiated on 6/19/2024: R9 has a behavior problem related to being impatient and irate and starts cursing at staff if he does not come the moment he turns the call light on. He is noted to keep old food containers in his room that attract gnats, and when staff attempt to throw containers away, he will not allow staff to do so. All interventions to address this care area were developed on 6/19/2024, and one intervention was noted to Assist the resident to develop more appropriate methods of coping and interacting. [sic] Psychotropic Medication care plan last revised on 9/30/2024: R9 uses psychotropic medications related to anti-depressant. He is at risk for complications related to psychotropic medication use. All interventions to address this care area were developed on 6/13/2024, and one intervention was noted for R9 to receive psych services as needed. Depression care plan initiated on 6/20/2024: R9 is at risk for signs and symptoms of depression. All interventions to address this care area were developed on 6/20/2024, and one intervention noted arrange for psych consult, follow up as indicated. There were no interventions documented in the care plans that addressed the resident's behaviors that were detailed in the written warnings given to R9 on 7/10/2024, 7/12/2024 and 7/29/2024. Review of R9's Social Services progress notes completed by the facility's SSD revealed: 7/10/2024 at 10:45 am: This worker and SS assistant spoke with resident. This worker informed resident that he was getting 2 written warnings, one for his behavior towards staff such as yelling and cussing at them and two for trying to enter a female resident room yesterday and when told he was not allowed, he was disrespectful to staff. Resident acknowledged understanding and signed both warnings. [sic] 7/12/2024 at 2:06 pm: This worker and SSD spoke with resident. This worker informed resident that he was getting 1 written warnings, one for his behavior towards staff. Resident refused to sign and asked to speak with admin. Admin and this worker tried to explain that the way we talk does matter and we do need to think about the things that are said directed or indirect at staff members. [sic] 7/29/2024 at 4:00 pm: Both social workers spoke with reason regarding his final written warning that was given today and discussed. Informed resident that he was getting a 30-day discharge and gave him a copy of the letter. Resident refused to sign the written warning or the discharge letter. Email sent to ombudsman. [sic] Continued review of R9's Social Service Progress Notes revealed there was no documentation in reference to seeking psychological services to address the resident's behavioral issues. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R9's Behavioral Health Note dated 9/26/2024 noted the resident was seen for Diagnostic evaluation for bipolar disorder with recent behavioral disturbance .He is being seen today for behavioral disturbance secondary to bipolar disorder. Patient reports that he has verbal outburst and gets extremely angry. He is triggered by small and insignificant events such as the coffee cart being moved. He becomes irate and will curse at staff. He is not usually able to be reasoned with when he is upset. His symptoms have been present since he was a child He is currently managed on sertraline alone and does not feel the medication is effective .Medical Decision-Making (symptom change, rationale for treatment plan, testing, diagnostic rule-outs): I plan to increase sertraline and start the patient on a mood stabilizer such as Lamictal. SSRIs alone are not recommended for bipolar disorder. In combination with mood stabilizer, may be beneficial .Staff to increase support and attempt to remove other residents from the patient's presence when he is upset .Patient would likely benefit from counseling but insurance limits coverage .Plan and recommendations .Medication Changes: Increase sertraline to 100 mg po q day; Start lamotrigine [Lamictal] 25 mg po bid. During a telephone interview on 10/1/2024 at 3:47 pm, the Ombudsman said he was aware that R9 received a 30-day discharge, and that the warnings the resident received were related to behavioral issues. The Ombudsman said that he was not aware of any steps the facility may have taken to address the resident's behavioral concerns. In an interview on 10/2/2024 at 2:35 pm, the SSD stated she did not refer R9 for psychological services because the resident did not have a payor source, and the vendor that the facility used for psychological services would not accept private payment from the facility to provide services for the resident. The SSD stated that she did nothing further to initiate psychological services for R9. At the time of the interview, the SSD did not recall the behaviors for which R9 received the warnings. During an interview on 10/2/2024 at 2:45 pm, the facility's Director of Nursing (DON) confirmed that R9 was administered the lowest dose of sertraline between 6/4/2024 and 9/26/2024. The DON stated that nursing staff arranged for the resident to be seen for psychological services on 9/26/2024, and at that time, his sertraline was increased and a mood stabilizer (Lamictal) was added to the resident's drug regimen. The DON further stated that R9 was not seen by psychological services prior to 9/26/2024 due to issues with the resident's payor source and said that the SSD would be the person responsible for following up on that issue.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25117 Based on observations, staff interviews, and review of the facility's policy titled, Cleaning Cycle, the facility failed to provide a safe, clean, and comfortable environment in three of six units of the facility (Unit 400, Unit 500, and Unit 600). Specifically, the facility failed to maintain an environment free of a strong odor of urine in resident rooms, bathrooms, and unit hallways. This deficient practice had the potential to place residents at risk of living in an unsanitary living environment and a potential for diminished quality of life. Findings include: A review of the facility's policy titled, Cleaning Cycle, dated revised 3/1/2024, stated, The frequency of cleaning and disinfection of the facility environment may vary according to the: a. Type of surface to be cleaned. b. The number of individuals in the area. c. Amount of activity in the area. d. Risk to residents. e. Amount of soiling. In addition, the policy stated, The Environmental Services Manager is responsible to ensure that cycle cleaning is maintained. On 10/1/2024 at 1:15 pm, observations were conducted on the 400, 500, and 600 units of the facility. During the observations, a strong odor of urine was present in the hallways of the three units. Observations conducted in the shared bathroom for resident rooms [ROOM NUMBERS] revealed the flooring around the base of the toilet was discolored by urine stains and there was also urine around the base of the toilet. On 10/1/2024 at 3:00 pm, Housekeeper FF and Housekeeper HH were observed on the 400, 500, and 600 units of the facility cleaning the hallways. Further observations revealed there were no cleaning carts observed on the units. Housekeeper FF and Housekeeper HH could not provide a location for the cleaning carts at the time of the observation. At the time of the observations, Housekeeper FF and Housekeeper HH were using dust mops in the unit hallways. In an interview on 10/1/2024 at 3:10 pm, Housekeeper EE stated bathrooms in the facility should be cleaned every two to three hours. Housekeeper EE further stated there were a lot of male residents who lived on the 400, 500, and 600 units of the facility who consistently urinate on the floors in the bathrooms, and urine soaks the wax flooring and stains the floor around the base of the toilets. In an interview on 10/1/2024 at 3:15 pm, the Director of Maintenance and Housekeeping (DMH) stated he served as the Director of Maintenance in the facility and served as the Environmental Services Manager. The DMH stated he was aware that the bathroom floors were stained and facility housekeepers had to constantly clean urine from the floors around the toilets. The DMH stated the facility used a urine remover cleaning agent that should eliminate urine odors. However, an inspection of the housekeeping carts with the DMH revealed two of the five cleaning carts were not supplied with the urine remover cleaning agent. The DMH further stated housekeepers should have cleaning carts when they performed their duties on assigned units of the facility and was not aware Housekeepers FF and HH did not have cleaning carts while working on the 400, 500, and 600 units of the facility. The DMH did not specify how often resident bathrooms should be cleaned. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/1/2024 at 3:50 pm, the Ombudsman stated his last visit to the facility was 7/16/2024, and there was a noticeable urine odor on the 400, 500, and 600 units of the facility. On 10/2/2024 at 9:00 am, additional observations of Units 400, 500, and 600 revealed a strong odor of urine in the hallways, resident rooms, and bathrooms on the units. The DMH was observed cleaning the floors around toilets located in resident rooms. In an interview on 10/2/2024 at 10:00 am, Housekeeper GG stated Units 400, 500, and 600 always smell like urine because male residents who lived in those units urinate on the floors in their bathrooms. Housekeeper GG further stated she tried to clean resident bathrooms several times during a shift.